EDITORIAL
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# COVID-19 and breast cancer: Should we change prevention, control, and treatment strategies or intelligently rationalize our practice?

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> You will not be right or wrong because the crowd does not agree with you. You will be right because your data and reasoning are correct (Benjamín Graham).

On December 12th, 2019, the world was routinely normal and the news very briefly mentioned some cases of a rare viral pneumonia observed in Wuhan, Hubei province, China.

Between December 30th and January 3rd, 2020 everything changed drastically. A rare epidemic was first reported in a chat and was later denied in a document by the very same person who reported it, the Chinese ophthalmologist Li Weliang, under pressure from the country's government "accusing him of spreading false rumors"[1].

Two days later, the World Health Organization (WHO) issued an alerted regarding an outbreak of pneumonia of unknown etiology in Wuhan[2], and only on January 7th did the Chinese authorities report having identified a new virus causing the new disease, 2019-nCoV[3].

On February 6th, Li Weliang died of coronavirus. And then chaos was unleashed — cases multiplied, the disease spread to various countries and continents and the concept of "normal" life have probably changed forever.

The first test to show that the aggressive quarantine approach was the right way to go was published in late February by a WHO commission that visited several Chinese cities. Unfortunately, the Chinese example was not replicated in many countries[4].

The final corollary of the start of this new global scenario occurs on March 11th, 2020, when the WHO declares that the outbreak of the disease, renamed COVID-19, is a Pandemic.

What is the purpose of this editorial? Indeed, one must accept that the concepts of private and social lives and medical practice, as we know it, will be no more, and not to accept it as it is would be foolish; but accepting it does not mean being submissive as a herd (later I will delve into this concept), given the overwhelming amount of information in our times, in dozens of scientific articles and recommendations published every day online (more than 6,000 in PubMed) and on social networks, which combine solid data with rumors and fake news.

People are constantly stating that the human kind faces an unknown and threatening disease that is often severe and deadly, that health systems are overloaded, that there is no proven treatment to date, that vaccines will not be available in a short period of time, and that a situation like this has not occurred since the influenza pandemic in 1918.

Is this an unquestionable reality, though? Is it the same for all countries with different demographic densities, geographies, climates and health policies? Is it the same for all the provinces, cities, and counties of our country?

Now, pointedly regarding our specialty, how should we proceed in the face of this new challenge? Changing our diagnostic and therapeutic strategies? Changing our prevention strategies? Should we avoid under-treating tumors for fear of the pandemic? Should we put ourselves on the brinks of ethical conflict upon having to decide who should be controlled and/or treated and who should wait?

Provided we analyze the personal and the collective in our professional activities, how should we take care of ourselves? How to care for patients? What new legal conflicts can we face? How is this new scenario going to impact our mental health and quality of life? What precautions can and should we take?

Thus, I will honestly and modestly give you my impressions on these matters, based on more than 40 years of profession, most of which practicing Mastology, and having the same experience in the pandemic as all of you, practically nil, apart from solely information with levels of evidence 5. I am not an epidemiologist, nor an infectious disease physician or a pulmonologist. My role, as yours, is to treat my breast cancer patients in the most medically and ethically correct way and to avoid the work team's contagion.

In order to answer these questions, I need first to go back to the definition of the term "herd". It was used in this Pandemic to explain the policy of some countries such as the United

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Kingdom, where the Prime Minister introduced it to achieve "collective immunity" with widespread exposure of the majority of the population and to thus avoid future epidemics. It did not go well, to such an extent that he ended up in an intensive care unit as a victim of the disease and of his own strategy.

In fact, I would like to use another term for it, also conceptualized as "gregarious behavior", which has to do with "the tendency to accept the reasoning or ideas of the majority as valid without analyzing whether they are logically correct". To date, doctors are probably acting guided by many contradictory recommendations, or ones established for other realities, situations or institutions, and which are not rationalized by passing on through the filter of our experience and common sense.

The best way to avoid the "herd effect" is to ask ourselves: What data are we basing ourselves on? Is there a scientific study that confirms this? Is there a scientific study that denies it? Are these studies rigorous? Does it make sense from a logical point of view?

You have probably read the recommendations of various international organizations, consensus and even pieces published by SAM[5-10] on the management of breast cancer in this situation.

In general, they are all based on different scenarios and stages of the pandemic, so they only serve as models to be evaluated and adapted to each institution with its advantages and disadvantages, its estimation of supplies, availability of normal hospital beds, of feverish patients (COVID + or not) or intensive care ones, staff turnover, possibility of serial tests, infected quarantined staff with or without symptoms of the disease.

For example, systematic testing depends on a country's or institution's health possibilities and the risk groups included therein; however, these priority criteria have been expanded for various reasons. To date, the WHO has recommended all countries to massively perform diagnostic test.

Then, what should we do or prioritize with these recommendations? I believe there is only one answer: to rationalize them, and to do it personally and intelligently, contemplating the dynamics of the pandemic and our reality at the moment of taking action.

In relation to health personnel, the conduct is clear, we must rotate it, maintain independent work teams equipped with adequate prevention teams and staff, who can continue care in case of infections and treat according to the available means of routinely testing them, in addition to holding continuous multidisciplinary videoconference meetings for assistance and decision-making, information, physical prevention and individual and group psychological support[11,12].

Regarding patients, the conduct should be telephone or e-mail assistance prioritizing control consultations to balance the cost-benefit of postponing the visit to lower the risk of contagion, mandatory triage, questioning about the history of possible exposure, indication and detailed information on the conduct decided by the multidisciplinary team of risks related to the treatments and the possible occurrence of COVID, prior testing of patients who will undergo surgical and/or chemotherapy treatments. It is paramount to take into account the analysis of high-risk groups by age, associated morbidities or immunosuppression.

In relation to the diagnosis, control or screening studies in asymptomatic women and, in some situations, studies on previous injuries categorized as Birad 3, should probably be postponed. In the remainder of the situations, studies should be done considering each case individually.

As for treatment, the institution's overall status and the stage of complexity of the pandemic should be assessed at all times, and if the two parameters are favorable, conventional treatments should be indicated, taking the previously mentioned safety precautions by both patients and surgical teams (screening, interview, testing, etc.). It should be noted that we are talking about oncological surgeries with or without previous neoadjuvant, favorable or advanced primary tumors that may include immediate reconstructions with expanders or prostheses or mastoplasty techniques that do not significantly increase surgical time nor increase the costs on essential supplies as well as any type of complication that needs to be resolved in the operating room. It makes no sense, at this time, to include treatments for benign pathologies, potential risk injuries, risk reduction surgeries, and delayed breast reconstructions.

A special paragraph should be dedicated to patients with asymptomatic COVID and breast cancer in relation to the actions to be taken. Although controversial, it is likely that the most prudent is take a "therapeutic time out" until the tests are negative and treatments can be started in a safer setting to avoid increased postoperative complications[13].

The fundamentals of providing patients with detailed information about the implications of the pandemic, the safety measures being taken by us, and the multidisciplinary decision-making and its reasons, are never to be forgotten, but rather to be reported into the clinical history and informed consent for signature.

Within time, there are likely to be specific situations that will be analyzed legally in another context and the health team may find itself questioned for behaviors taken in an exceptional situation that generates this global health emergency.

The COVID epidemic started in December 2019. In many countries, the commotion generated by quarantining has faded, the number of infected people is decreasing, and measures on how to lift the blockade are being discussed. But are appearances misleading? Is a second wave approaching? If so, when would it occur? Science continues to advance. Soon, the first drug trials will pay off, and the first vaccines are already being tested.

Once the situation is resolved, what urgent steps will have to be taken in the breast cancer scenario? Will it be possible to return to the starting point?

We should try to quickly return to normality, while still taking advantage of the lessons learned from our personal and group experiences, and to elaborate and define precise contingency plans in case of outbreaks, until we can achieve the long-awaited goal of being able to immunize the entire population.

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